Pennsylvania Association of
Staff Nurses & Allied Professionals

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Testimony for Informational Hearing on the Nursing Workforce Crisis
House Labor & Industry Committee
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Good morning. My name is Maureen May, and I've been a bedside nurse for over 38 years in Critical Care, Maternal Health, and the NICU. I love what I do and am proud to be a nurse. While I work at the bedside, I also serve as the President of PASNAP, the Pennsylvania Association of Staff Nurses and Allied Professionals, representing about 11,000 healthcare workers.

I would like to thank Chairman Dawkins, Chairman Mackenzie, and members of the House Labor Industry and Committee for allowing me to speak today about something really important to those at the bedside, especially as we celebrate Nurses Week.

Many of you in this room have been told, "There are not enough nurses to work in hospitals," or "The hospitals are trying, and they just can't find nurses." I'm sure you've all heard that.

I am here to give you a different perspective on the workforce crisis. While it is true that we need to expand our pipeline of nurses and work on providing more resources to get nurse educators into the system, the real problem is inside the hospitals.

You can recruit nurses into the profession all you want, but if we do not fix the working conditions in the hospital, nurses, by and large, don't stay very long. As of last year, the Hospital and Healthsystem Association of Pennsylvania cited that they had a 30% turnover rate for nurses in hospitals. That was the hospital association's very own data. That was one of their reasons for opposing the Patient Safety Act. I've read that it's come down slightly over the last year to 28%, but a retention problem remains: nurses are still not staying in hospitals for long.

Why is that? The problem is the working conditions. Between unacceptable staffing levels and escalations in workplace violence, nurses are finding other things to do with their licenses or taking early retirement. We have the nurses in PA, but they're sitting on the sidelines. They don't want to subject themselves to moral injury and risk their license or personal injury, so they have decided to do other things. We can get them back to the bedside – but for that to happen, the working conditions must improve.

I want to thank the committee for today's consideration of the Healthcare Workplace Violence Prevention Act, House Bill 2247. I also want to thank Rep. Leanne Krueger and Rep. Bridget Koserowski for their leadership on this issue. This conversation about workplace violence in a healthcare setting has been long overdue and is desperately needed. Our members have countless stories. When we talk about workplace violence, we're not referring to cases where the patient accidentally did something after coming out of anesthesia, for example. We're talking about cases where the violence is intentional.

I know this is not a hearing specifically about House Bill 2247, but it is related to the topic, so I will discuss it briefly. In any other profession, if someone were assaulted at work, it would be dealt with in the most serious manner. But for some reason, in the healthcare field, in particular nursing, where the vast majority in the profession are women, workers are expected to absorb it, walk it off, and they go home often wondering, "Who's protecting me?". Hospital management's response in countless cases of workplace violence is often less than adequate.

We have examples, some of which are truly horrific, about workplace violence. For example, a tech in a city hospital had their finger bitten off and then spit across the room. The ER had to amputate the remaining part of the employee's finger. Regardless of the patient's mental state, can we all agree that's unacceptable?

In some hospitals, the security guards who respond are not allowed to touch the patient acting violently. What's the point in that scenario?

Nurses are highly trained clinical professionals – we are not punching bags. We are not people who are willing to accept being stabbed, punched, bitten, pushed, shot, spit on, threatened – you name it.

We have an example of one nurse who was punched in the face so severely that she required reconstructive surgery and had a brain injury. That nurse will likely never be able to work again. Can we all agree that's unacceptable as well?

We have shared examples of workplace violence incidents from around the state with the Committee. There are countless stories at the bedside - and they occur everywhere – at urban, suburban, and rural facilities.

Now, violence itself is not the fault of the hospitals, but the lack of response, remediation, and preparation to ensure that we have the policies, procedures, and equipment that we need to prevent workplace violence – is the hospitals' responsibility. It is their fault when the system breaks down. Employees are asking for a seat at the table to discuss how to make their workplace safer. That's all – to be part of the conversation and help design procedures and plans.

I want to thank the committee for advancing the discussion on workplace violence prevention in healthcare facilities. This is important and one reason the nursing workforce crisis is here. Hospitals need to do better.

I also want to mention that spikes in aggression and violence from patients and patient families occur more frequently when they are frustrated they or their loved ones aren't getting enough attention due to poor staffing. These issues are, unfortunately, linked.

Poor nurse staffing levels are the number one reason nurses are leaving. When you graduate nursing school, you have one vision of what it is to be a nurse. It's entirely different when you're thrown into the deep end of the pool, and in some cases throughout the Commonwealth, nurses have been given 11 patients at a time. That's not all places, but anything over four patients is unsafe and leads to negative outcomes.

If there are too many patients, nurses cannot catch all the signs of medical decline and intervene in a timely manner. How would you see if two or three patients were coding simultaneously? What would you do? Which one would be the priority? Those questions are not fair to the patient and to the nurse.

Many of us on the drive home from work are frustrated that we couldn't give 100% of the best quality care possible, the kind of care that any patient would want. And that's not the nurse's fault.

Hospitals don't like to hear this, but it is the case: trying to staff the hospital with the fewest nurses possible is sort of their business model and has been for years. The problem was here, even before the Pandemic—it had just gotten worse. Unfortunately, this issue for hospitals is about money. Many of you on this committee voted in favor of HB106 on the House floor and advanced the legislation for Safe Staffing Ratios last June, and we thank you for that.

We're not going to stop advocating for these two issues. We hope we can get them across the finish line this year. But if time runs out, we'll be back—because it's too important to give up on these vital pieces of legislation that impact the bedside.

I'll leave you with one last note: thank you for holding this hearing today, during Nurses Week, because the discussion about the nursing workforce crisis—often doesn't include the people at the bedside. Hospital administration and nurse managers are discussing it in the halls of Harrisburg, but bedside nurses have a pretty good idea of what the problem is and what's causing it.

I'm sure you will hear from the hospital association and other hospital networks about how they do not like the Healthcare Workplace Violence Prevention Act – HB2247 for one reason or another. You heard their opposition to the safe staffing bill – HB106 last year. But at the end of the day, what they are saying to you is that —"we want to keep the status quo," ——

and what bedside nurses and healthcare professionals say to you is that “the status quo is not acceptable nor sustainable.”

Thank you for your time.